STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	01/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRACE AT SOLARBRON THE	1701 MCDOWELL RD EVANSVILLE, IN 47712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaint IN00102912. Complaint IN00102912 - Substantiated. Federal/State deficiencies related to the allegations are cited at F309 and F327. Survey dates: January 30 and 31, 2012 Facility number: 010930 Provider number: 155773 AIM number: N/A Survey team: Anne Marie Crays RN Census bed type: SNF: 32 Residential: 35 Total: 67 Census payor type: Medicare: 19 Other: 48 Total: 67 Sample: 4 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 2/6/12 by Jennie Bartelt, RN.	F0000	Preparationand Execution of this Response and Plan of Correction do notconstitute an admission or agreement by the provider of the truth ofthe facts alleged or conclusion set forth in the statement ofdeficiencies. This Plan of Correction is prepared and/or executedsolely because it is required by the provisions of federal and statelaw. CredibleAllegation of Correction and Compliance: Forpurposes of any allegation that The Terrace at Solarbron is not incompliance with the regulations as set forth in this statement ofdeficiencies, this Plan of correction constitutes the facility'scredible allegation of correction and compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F0309 SS=G	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.			
	Based on interview and record review, the facility failed to ensure a resident with change in condition was assessed for distention of the bladder and signs and symptoms of dehydration. The deficient practice affected 1 of 4 residents sampled for dehydration and incontinence in a sample of 4. (Resident A) Resident A was transferred to the hospital emergency room and was admitted to the hospital. In the emergency room 2000 ml of urine was drained from the resident's bladder. Diagnoses at the time of admission included acute urinary retention, hyponatremia, and hypokalemia. Findings include: On 1/30/12 at 3:30 P.M., the clinical record of Resident A was reviewed. The resident was admitted to the facility on 11/9/11 with diagnoses including, but not limited to left femur fracture and urinary tract infection. Nurses Notes included the following notations: 11/9/11 at 5:30 P.M.: "Admitted to [room number]...Occ [occasionally] forgetful...Incont [incontinent] of bladder uses briefs, dribbles...needs assist for set up of oral care, meals. Assist [two] transfer...." A "Hydration Status Assessment," dated 11/9/11, indicated the resident had decreased food & fluid intake, dry skin & mucous membranes, and functional impairments. The assessment indicated	F0309	F309 ***Thecorrective action taken for those residents to be affected by thealleged deficient practice include:*** Resident“A” no longer resides at the facility as indicated in the 2567. RN#1 has been terminated. ***Otherresidents having the potential to be affected by the allegeddeficient practice have been identified by:*** All residents have been assessed related to hydration status and risk for dehydrationwith appropriate interventions implemented based on the assessment. ***Themeasure or systemic changes that have been put into place to ensurethat the alleged deficient practice does not recur include:*** All resident have been assessed relating to their hydration status with appropriate interventions implemented based on the assessment. The Hydration StatusAssessment will be completed upon admission, re-admission from thehospital, quarterly, and upon change in condition. Residents identified as “at high risk” upon admission will be placed on 3-day Intake & Output monitoring. If the resident is not meeting recommended fluid	02/21/2012

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	the resident was not on a diuretic, had no renal impairment or edema, was not lethargic, had no abnormal lab results of electrolyte imbalance, and had no increased fluid needs. The resident's total score on the assessment was 3 ["If 8 or above, MD to be notified & hydration management interventions followed"]. An Interdisciplinary Care Plan, dated 11/9/11, indicated, "Resident diagnosed with UTI [urinary tract infection]." Approaches included: "Offer and encourage intake of fluids...." An additional Interdisciplinary Care Plan, dated 11/9/11, indicated, "Resident has potential for complications related to urinary elimination due to urinary incontinence, overactive bladder." Approaches included: "Monitor for complications or c/o [complaints of] dysuria [difficulty urinating], frequency...reduced urine output...Encourage adequate fluid intake...." Nurses Notes continued: 11/10/11 at 2:00 P.M.: "...Res [resident] will respond weakly to questions, takes sips H2O[water] [with] assist. Required to be fed for meals, takes few bites...Incontinent of urine x 4...." 11/11/11 at 6:30 A.M.: "...Incontinent of bladder, denies pain or burning upon urination. Cont [continues] on ATB [antibiotic] for UTI [urinary tract infection]...Res does c/o [complain of] frequency...." 11/11/11 at 1:00 P.M.: "Call out to [name of physician] office r/t [related to] pain medication...Pt [patient] noted to be lethargic when taking...[No] NO's [new orders] @ this time."		intake goals, the resident will remain on Intake & Outputmonitoring until the intake is adequate according to the residents physician. All residents identified as having a Urinary TractInfection will also be placed on Intake & Output monitoring until the infection has been resolved. To improvecommunication, the “at high risk” residents's status will be reviewed at each shift change in nursing personnel. Included in the information is the resident's Intake & Output status. A daily(Monday through Friday) status report on “at risk residents” willbe given to the Director of Nursing or designee for review and recommendations and/or interventions. Nursing personnel have been in-serviced on providing accurate and complete assessmentswhich are to include conducting bladder palpitations and implementing plans of care based on information from the assessment. Nursing personnelhave been in-serviced on the Hydration Policy and the new forms which include the Hydration Status Assessment and Intake & Output Shift Monitoring Tool/Binder. ***Thecorrective actions to monitor performance to assure compliancethrough quality assurance are:*** The Director ofNursing or designee will ensure that the new monitoring tools arebeing utilized. A Performance	

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	11/11/11 at 1:05 P.M.: "...Remains on ATB for UTI...Taking fluids well [with] encouragement et [and] staff queing [sic] pt while eating. Continues to c/o lethargy et weakness...." 11/11/11 at 5:00 P.M.: "Pt c/o nausea earlier...." 11/12/11 at 2:00 P.M.: "...Remains on ATB for UTI...Complains of urinary frequency, no pain or burning with urination...." 11/12/11 at 6:30 P.M.: "...Taking fluids [without] problems. Encouraged to eat when offered. Pt takes bites only." 11/13/11 at 5:00 A.M.: "...ATB for UTI...fluids encouraged [and] well taken...." 11/14/11 at 2:00 P.M.: "...N.O. received for Levaquin [antibiotic] et Lasix [diuretic]...Res c/o some nausea...." 11/14/11 at 9:15 P.M.: "Offered water at this time, drank well with encouragement. Denied need to use bathroom...." An Interdisciplinary Care Plan, dated 11/14/11, indicated, "Resident at risk for fluid volume deficit R/T [related to] Diuretic Use." Approaches included: "Monitor and report to physician signs and symptoms of dehydration...Physical signs & symptoms of dehydration. Discuss with resident any concerns about fluid intake. Encourage fluid intake with and between meals. Observe for S/S [signs and symptoms] of dehydration & report to nurse:...Cracked lips, Dry mucous membranes, Dry skin/poor skin turgor, Dark urine, Poor fluid intake/thirst...Increased confusion...." A Nutrition Risk Assessment, dated 11/15/11, indicated, "...Diet order, Mech [mechanical] soft		Improvement Tool has been established that will randomly review 5 residents to ensure that services are being provided in accordance with the physician's orders, the written plan of care relating to areas of “high risk” identified by assessments, and adherence tothe Hydration Policy. This tool will be completed by the Director of Nursing, or designee, weekly X3, monthly X3, then quarterly X3. Any issues will be immediately corrected. The completed audits will bereviewed at the routinely scheduled Quality Assurance Meeting with additional recommendations as needed for one year.	

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	[with] gr [ground] meat...Eating ability: Needs Tray Setup, Partial Assist/Cueing...Average fluid intake fair...Nutritional Needs Estimation...Fluid Needs (mL): 1590 mL...." An additional Interdisciplinary Care Plan, dated 11/15/11, indicated, "...Potential for alteration in nutrition r/t diagnosis: [Left] femur fx [fracture] [and] repair...UTI [and] pneumonia." Approaches included: "Monitor food/fluid intake." Nurses Notes continued: 11/15/11 at 4:30 A.M.: "...Refused to get up to the bathroom [and] used bedpan x 2...Continues on ATB for UTI...." 11/16/11 at 4:15 A.M.: "...Has been Inc x 1 this shift. Refused to get up [and] go to Bathroom. Has not used bedpan...Has drank plenty of fluids...." A Physical Therapy progress note, dated 11/17/11 and untimed, indicated, "Pt very lethargic today. Pt unable to eat breakfast per daughter. Pt had to be woken from a 3 hour nap...Pt could hardly keep head up in wc [wheelchair]...Pt tol [tolerance] very poor today. RN notified." A note faxed to the physician, dated 11/17/11 and untimed, indicated, "Pt has an order for Flexeril 5 mg [a muscle relaxer]...but this is very sedating. Pt describing restless leg syndrome symptoms @ night et [and] is unable to sleep. Could we maybe try Requip?" An additional note faxed to the physician, dated 11/17/11 and untimed, indicated, "[Resident A] is currently on ATB for a poss [possible] dx [diagnosis] of pneumonia. She has an occ [occasional] weak cough, productive @ x's [times], do you think a PRN [as needed] Albuterol			

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	[nebulizer] tx [treatment] would help her...." A dietician note faxed to the physician, dated 11/17/11 and untimed, indicated, "Resident was seen by dietician [and] made the following recommendations...Residents [sic] wt. this week is 109 lbs (wt loss of 7 lbs x 1 wk). PO [by mouth] intake is poor to fair. Would like to add 90 cc Med Pass TID [three times daily] as supplement." Nurses Notes continued: 11/17/11 at 1:30 P.M.: "...Taking fluids well [with] encouragement...." 11/18/11 at 4:00 P.M.: "...Pt remains weak. Not taking much nutrition. Encouraging med pass and magic cup when does not eat...Incont of Bowel [and] bladder. Wears briefs...." 11/18/11 at 7:30 P.M.: "Called to pt room. Had large incontinent stool...Abd [abdomen] distended, hard knot noted @ umbilicus area. Nontender to palpation, done very gently. Abd mass firm to touch...New order need to transport to [name of hospital] ER [emergency room] for evaluation if family wishes." The resident was transferred to the hospital on 11/18/11 at 7:50 P.M. A hospital emergency room note, dated 11/18/11 at 10:59 P.M., indicated, "...The patient was evaluated shortly after arrival...She was noted to have a large lower abdominal pelvic mass which appeared to be bladder distention initially on evaluation. She is very weak and dehydrated in appearance with dry oropharynx findings...She had a Foley catheter placed and drained almost over 2000 mL of urine...She does have a panic values sodium level of 118. She was started on some IV			

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	fluids...Final Impression, Abdominal pain, acute urinary retention, Altered mental status, hyponatremia [low sodium], hypokalemia [low potassium]...." A facility Food Intake Record, dated November 2011, indicated the resident consumed the following amounts of fluid: 11/10: 520 cc, 11/11: 530 cc, 11/12: 380 cc, 11/13: 480 cc, 11/14: 660 cc, 11/15: 720 cc, 11/16: 720 cc, 11/17: 580 cc, 11/18: 180 cc. A facility Resident Care Record, dated November 2011, indicated the resident was incontinent of bladder 7 times on 11/16, 6 times on 11/17, and 8 times on 11/18. The record did not specify the amount of the urine. On 1/31/12 at 9:20 A.M., during interview with RN # 1, she indicated she was the nurse who was working on 11/18/11 and transferred Resident A to the hospital. RN # 1 indicated she did not think the abdominal mass felt like a distended bladder. She indicated she felt like "something else must have been going on." RN # 1 indicated she knew the resident had been having wet briefs, and was on an antibiotic for a UTI. RN # 1 indicated she thought the resident had a previous history of "bladder problems." On 1/31/12 at 10:30 A.M., during interview with the Administrator and MDS Coordinator, they indicated the family of Resident A stayed with the resident frequently, and frequently would not let staff wake the resident to feed her or give her fluids. The Administrator indicated the nurse who transferred the resident to the hospital was not a new nurse, but an older more experienced nurse. This federal tag relates to Complaint IN00102912.			

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	3.1-37(a)			

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F0327 SS=G	The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. Based on observation, interview, and record review, the facility failed to ensure a resident received sufficient fluid intake to prevent dehydration, resulting in hospitalization for dehydration, for 1 of 4 residents sampled for hydration, in a sample of 4. Resident A Findings include: On 1/30/12 at 1:25 P.M., during the initial tour with the MDS [Minimum Data Set] Coordinator, water pitchers or bottles were not observed at the bedside of dependent residents. On 1/30/12 at 3:30 P.M., the clinical record of Resident A was reviewed. The resident was admitted to the facility on 11/9/11 with diagnoses including, but not limited to Left femur fracture and Urinary tract infection. Nurses Notes included the following notations: 11/9/11 at 5:30 P.M.: "Admitted to [room number]...Occ [occasionally] forgetful...Incont [incontinent] of bladder uses briefs, dribbles...needs assist for set up of oral care, meals. Assist [two] transfer...." A "Hydration Status Assessment," dated 11/9/11, indicated the resident had decreased food & fluid intake, dry skin & mucous membranes, and functional impairments. The assessment indicated the resident was not on a diuretic, had no renal impairment or edema, was not lethargic, had no abnormal lab results of electrolyte imbalance, and had no increased fluid needs. The resident's total score on the assessment was 3 ["If 8 or above, MD to be notified & hydration management	F0327	**F327** It is the practice of the Terrace at solarbron to ensure that each resident is provided sufficient fluid intake to maintain proper hydration. ***Thecorrection actions taken for those residents found to be affected bythe alleged deficient practice include:*** Resident “A” has been discharged from the facility as indicated in the 2567. Nurse #1 has been terminated. ***Otherresidents that have the potential to be affected by the allegeddeficient practice have been identified by:*** All resident have been assessed related to hydration status and risk for dehydration with appropriate interventions implemented based on the assessment. ***Themeasures or systematic changes that have been put into place toensure that the alleged deficient practice does not recur include:*** HydrationRe-Assessments have been completed on all residents. The assessment will be completed on admission, quarterly, if a resident returns from the hospital, or has a significant change in condition. Based on the assessment, appropriate interventions will be implemented as indicated for each resident. The plans of care have been updated toreflect any needed interventions based on	02/21/2012

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	interventions followed"]. An Interdisciplinary Care Plan, dated 11/9/11, indicated, "Resident diagnosed with UTI [urinary tract infection]." Approaches included: "Offer and encourage intake of fluids...." Nurses Notes continued: 11/10/11 at 2:00 P.M.: "...Res [resident] will respond weakly to questions, takes sips H2O [water] [with] assist. Required to be fed for meals, takes few bites...Incontinent of urine x 4...." 11/11/11 at 6:30 A.M.: "...Incontinent of bladder, denies pain or burning upon urination. Cont [continues] on ATB [antibiotic] for UTI [urinary tract infection]...Res does c/o [complain of] frequency...." 11/11/11 at 1:00 P.M.: "Call out to [name of physician] office r/t [related to] pain medication...Pt [patient] noted to be lethargic when taking...[No] NO's [new orders] @ this time." 11/11/11 at 1:05 P.M.: "...Remains on ATB for UTI...Taking fluids well [with] encouragement et [and] staff queing [sic] pt while eating. Continues to c/o lethargy et weakness...." 11/11/11 at 5:00 P.M.: "Pt c/o nausea earlier...." 11/12/11 at 2:00 P.M.: "...Remains on ATB for UTI...Complains of urinary frequency, no pain or burning with urination...." 11/12/11 at 6:30 P.M.: "...Taking fluids [without] problems. Encouraged to eat when offered. Pt takes bites only."		the assessment finds. The Registered Dietician has reviewed all residents in the facility and updated, if applicable, recommended fluid requirements. The Registered Dietitian will review residents on a quarterly basis orif there is a change in resident status. Based on the Registered Dietitian's recommendations, they dietary fluid needs have been posted/updated to reflect that most of the residents fluid intakesare served in accordance with the resident's meals. In addition, a hydration cart has been implemented that is provided X3 daily that will offer additional fluids to residents including those on thickened liquids. Nursing, Dietary and Activities staff have been in-serviced relating to offering of hydration to residents. ***Thecorrective actions taken to monitor performance to assure compliancethrough quality assurance is:*** A Performance Improvement Tool has been established that will randomly review 5 residents to ensure that services are being provided in accordancewith the physician's order and the written plan of care related to hydration. This tool includes the monitoring of fluids provided via meals, hydration carts, the plan of care, the intake records, if applicable, based on the residents' assessment of be at high risk or as been identified	

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	11/13/11 at 5:00 A.M.: "...ATB for UTI...fluids encouraged [and] well taken...." 11/14/11 at 2:00 P.M.: "...N.O. received for Levaquin [antibiotic] et Lasix [diuretic]...Res c/o some nausea...." 11/14/11 at 9:15 P.M.: "Offered water at this time, drank well with encouragement. Denied need to use bathroom...." An Interdisciplinary Care Plan, dated 11/14/11, indicated, "Resident at risk for fluid volume deficit R/T [related to] Diuretic Use." Approaches included: "Monitor and report to physician signs and symptoms of dehydration...Physical signs & symptoms of dehydration. Discuss with resident any concerns about fluid intake. Encourage fluid intake with and between meals. Observe for S/S [signs and symptoms] of dehydration & report to nurse:...Cracked lips, Dry mucous membranes, Dry skin/poor skin turgor, Dark urine, Poor fluid intake/thirst...Increased confusion...." A Nutrition Risk Assessment, dated 11/15/11, indicated, "...Diet order, Mech [mechanical] soft [with] gr [ground] meat...Eating ability: Needs Tray Setup, Partial Assist/Cueing...Average fluid intake fair...Nutritional Needs Estimation...Fluid Needs (mL): 1590 mL...." An additional Interdisciplinary Care Plan, dated 11/15/11, indicated, "...Potential for alteration in nutrition r/t diagnosis: [Left] femur fx [fracture] [and] repair...UTI [and] pneumonia." Approaches included: "Monitor food/fluid intake." Nurses Notes continued: 11/15/11 at 4:30 A.M.: "...Refused to get up to the bathroom [and] used bedpan x 2...Continues on		as having a Urinary Tract Infection. This tool will be completed by the Director of Nursing, or designee, weeklyX3,monthlyX3, then quarterlyX3. Any issues identified will be corrected immediately. The completed audits will be reviewed at routinely scheduled Quality Assurance meetings with additional recommendations as needed. Residents identified as “at high risk” or having a UTI which requires daily intake/output shift monitoring, will be reviewed daily by the IDT.	

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	155773	A. BUILDING 00 B. WING	01/31/2012

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	ATB for UTI...." 11/16/11 at 4:15 A.M.: "...Has been Inc x 1 this shift. Refused to get up [and] go to Bathroom. Has not used bedpan...Has drank plenty of fluids...." 11/17/11 at 1:30 P.M.: "...Taking fluids well [with] encouragement...." A Nutritional Progress Note, dated 11/17/11 at 9:00 A.M., indicated, "Residents [sic] wt [weight] 11/16/11 was 109 lbs, [down] 7 lbs x 1 wk [week]. Wt loss likely d/t [due to] both poor intake [and] some fluid loss d/t edema getting better from fx [and] repair...Intakes seem to be improving slightly...." Nurses Notes continued: 11/18/11 at 4:00 P.M.: "...Pt remains weak. Not taking much nutrition. Encouraging med pass and magic cup when does not eat...Incont of Bowel [and] bladder. Wears briefs...." 11/18/11 at 7:30 P.M.: "Called to pt room. Had large incontinent stool...Abd [abdomen] distended, hard knot noted...New order need to transport to [name of hospital] ER [emergency room] for evaluation if family wishes." The resident was transferred to the hospital on 11/18/11 at 7:50 P.M. A hospital emergency room note, dated 11/18/11 at 10:59 P.M., indicated, "...The patient was evaluated shortly after arrival...She is very weak and dehydrated in appearance with dry oropharynx findings...She does have a panic values sodium level of 118. She was started on some IV fluids...Final Impression, Abdominal pain, acute urinary retention, Altered mental status,			

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	hyponatremia [low sodium], hypokalemia [low potassium]...." A facility Food Intake Record, dated November 2011, indicated the resident consumed the following amounts of fluid: 11/10: 520 cc, 11/11: 530 cc, 11/12: 380 cc, 11/13: 480 cc, 11/14: 660 cc, 11/15: 720 cc, 11/16: 720 cc, 11/17: 580 cc, 11/18: 180 cc. At 1/30/12 at 4:40 P.M., during a confidential family interview, the family member indicated she was unsure if water or ice was passed routinely to residents. At 1/30/12 at 5:40 P.M., during interview with CNA # 1, she indicated staff does not pass fresh ice water, but that water bottles are kept in the residents' refrigerators or next to them. CNA # 1 indicated the residents "have sinks in their rooms too" to obtain water if needed. On 1/31/12 at 8:55 A.M., during interview with LPN # 1, she indicated, "Everybody has bottles of water in their refrigerators. Dietary staff pass them every morning." LPN # 1 indicated the facility does not pass ice to residents. LPN # 1 indicated she was unaware of how many bottles of water are passed per day, or how often. On 1/31/12 at 10:30 A.M., during interview with the Registered Dietician [RD], she indicated dietary staff makes sure there are 3-4 water bottles in each resident's refrigerator every morning. The RD indicated staff does not track how many water bottles are replaced for each resident. The RD indicated the meal consumption logs probably do not indicate all of the fluids a resident receives during a day. On 1/31/12 at 10:30 A.M., during interview with			

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	the Administrator, she indicated the family of Resident A stayed with the resident frequently, and frequently would not let staff wake the resident to feed her or give her fluids. The Administrator indicated the staff should have documented that fact more thoroughly in the chart. On 1/31/12 at 9:25 A.M., the MDS Coordinator provided the current facility policy on "Hydration of Residents," undated. The policy included: "Purpose: To ensure that all residents are assessed for dehydration risk and encouraged to consume enough fluids to ensure adequate hydration...Hydration will be maintained by provision of fluids through meal service, juice and/or water given with administration of medication, replenishing water bottles, and offering juice or water throughout the day. Residents who may be at risk for dehydration are: Residents with weight loss of 3 pounds or more in one month. Residents with dry skin and mucous membranes. Residents on diuretics...Residents with electrolyte imbalance...Residents with lethargy. Residents with fluid loss and increased fluid needs (e.g...infection). Residents with functional impairments (e.g. decreased mobility, ambulate with 2 assist, bed bound). Residents with swallowing problems...Licensed personnel are responsible for monitoring residents for signs and symptoms of dehydration and for notifying the physician if symptoms occur...Place water bottles at bedside...and encourage residents to drink frequently...Nursing staff will monitor all residents for signs of dehydration (ex: dry mouth, nausea, confusion), implement hydration interventions and notify the physician as needed...Interventions...Identify and offer resident likes for fluids...Provide extra fluids with UTI [urinary tract infection]/fever...Beverage easy access."			

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	This federal tag relates to Complaint IN00102912. 3.1-46(b)			